

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-000953

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 100

Primary Registration District No. _____

Registrar's No. 5

FILED JAN 14 1963

VS 300
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY Dent County		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Dent	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Salem, Missouri		c. CITY OR TOWN Salem, Missouri	
Length of stay in 1b 3 days		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Hart Hospital		d. STREET ADDRESS (If outside, give location) South Henderson, Salem, Mo.	
3. NAME OF DECEASED (Type or print) First Cora Middle Caroline Last McAllister		4. DATE OF DEATH Month January Day 5 Year 1963	
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 2-5-1882
9. AGE (last birthday) 80		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Housekeeping	
11. BIRTHPLACE (City and state or country) Dent County, Mo.		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13a. FATHER'S NAME James Russell Mooney		13b. MOTHER'S MAIDEN NAME Nancy Freeze	
14. NAME OF HUSBAND OR WIFE Andrew F. McAllister		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) X	
16. SOCIAL SECURITY NO. 3		17. INFORMANT Jasper McAllister, Salem, Missouri	
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO (b) chronic Hypertensive Cardiovascular Disease DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 4 Days unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Bronchial Pneumonia		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) _____	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	20f. CITY, TOWN, OR LOCATION _____		
20g. COUNTY _____		20h. STATE _____	
21. I attended the deceased from Jan. 3, 1963 to Jan. 4, 1963 and last saw her alive on Jan. 4, 1963 Death occurred at 2:25 a on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE [Signature] (Degree or title) MD	
22b. ADDRESS Salem, Missouri		22c. DATE SIGNED 1-7-63	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 1-7-63	23c. NAME OF CEMETERY OR CREMATORY Cedar Grove Cemetery	23d. LOCATION (City, town, or county) (State) Salem, Missouri
24. FUNERAL DIRECTOR SPENCER FUNERAL HOME INC. Salem, Mo.		25. DATE RECD. BY LOCAL REG. 1-7-63	
26. REGISTRAR'S SIGNATURE [Signature]			

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Carl H. Spinner

Licensed Embalmer No.

2370

P. O. Address

Salina Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.